STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

October 27, 2009

IN THE MATTER OF:

An Application for a Certificate of Need filed pursuant to Section 19a-638, C.G.S. by	Notice of Final Decision Office of Health Care Access Docket Number: 07-30999-CON
Windsor Dispensary Clinic, Inc.	**Proposal to Establish and Operate Methadone Maintenance and Ambulatory Detoxification Programs for Substance Abuse in Windsor**

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Dear Attorney Todisco:

This letter will serve as notice of the Final Decision of the Office of Health Care Access in the above matter as provided by Section 19a-638, C.G.S. On October 27, 2009, the Final Decision was rendered as the finding and order of the Office of Health Care Access. A copy of the Final Decision is attached hereto for your information.

By Order of the
Department of Public Health
Office of Health Care Access

Cristine A. Vogel
Deputy Commissioner

CAV:md

Enclosure

Copy: Michael Kurs, Esquire, Pullman & Comley, LLC

Department of Public Health
Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant:	**Windsor Dispensary Clinic, Inc.**
Docket Number:	**07-30999-CON**
Project Title:	**Proposal to Establish and Operate Methadone Maintenance and Ambulatory Detoxification Programs for Substance Abuse in Windsor**
Statutory Reference:	**Section 19a-638 of the Connecticut General Statutes**
Filing Date:	**September 29, 2008**
Hearing Date:	**November 6, 2008**
Intervenor:	**The Hartford Dispensary**
Presiding Officer:	**Cristine A. Vogel**
Decision Date:	**October 27, 2009**
Default Date:	**November 1, 2009**

Project Description: Windsor Dispensary Clinic, Inc. ("Applicant") proposes to establish and operate methadone maintenance and ambulatory detoxification programs for substance abuse in Windsor, Connecticut, at a total capital expenditure of $14,150.

Procedural History: On September 29, 2008, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application from the Applicant seeking authorization to establish and operate methadone maintenance and ambulatory detoxification programs for substance abuse in Windsor, Connecticut, at a total capital expenditure of $14,150.

Pursuant to Section 19a-638, C.G.S., a notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent to file its CON application was published in *The Hartford Courant* on July 17, 2007. OHCA received no responses from the public concerning the Applicants' proposal.

Pursuant to Section 19a-638, C.G.S., three individuals, or an individual representing an entity with five or more people, had until October 10, 2008, the twenty-first calendar day following the filing of the Applicant's CON application, to request that OHCA hold a public hearing on the Applicant's proposal. OHCA received no hearing requests from the public.

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on November 6, 2008. On October 20, 2008, the Applicant was notified of the date, time, and place of the hearing. On October 22, 2008, a notice to the public announcing the hearing was published in *The Hartford Courant.* Commissioner Cristine A. Vogel served as Presiding Officer. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Section 19a-638, C.G.S.

By petition dated October 31, 2008, The Hartford Dispensary requested Party status or Intervenor status regarding the Applicant's CON application. The Presiding Officer denied the request of The Hartford Dispensary for Party status and designated The Hartford Dispensary as an Intervenor with full rights of participation.

The Presiding Officer heard testimony from the Applicant's witnesses and the Intervenor's witnesses in rendering this decision and considered the entire record of the proceeding. OHCA's authority to review and approve, modify or deny the CON application is established by Section 19a-638, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

On December 24, 2008, OHCA denied the Applicant's proposal to establish and operate methadone maintenance and ambulatory detoxification programs for substance abuse in Windsor, Connecticut based upon a lack of need for the proposal. OHCA did not make any findings regarding the financial feasibility of the proposal. Subsequently, the Applicant appealed from the decision denying its application to the Superior Court on January 29, 2009, asserting that the Applicant had established need for the proposal. On May 19, 2009, the Applicant and OHCA entered into an agreement whereby the Applicant agreed to withdraw its appeal and OHCA agreed to undertake further review of the application solely with respect to the issue of the financial feasibility of the proposal. As part of the settlement, the parties agreed that the Applicant had established need for the proposal. The Applicant was also provided with an opportunity to request that OHCA open the record and allow the Applicant to submit additional evidence and/or argument with respect to the financial feasibility of the proposal.

On August 3, 2009, the Applicant provided written notice that it did not intend to submit additional evidence. Accordingly, pursuant to the terms of the agreement, OHCA has ninety days from the date of the receipt of the aforementioned notice, which is November 1, 2009, to render a decision on the financial feasibility of the proposal.

Findings of Fact

Background Facts

1. Edwin Njoku, MD, established the Windsor Dispensary Clinic, Inc. ("WDC" or "Applicant"), a not-for-profit corporation, to provide substance abuse services. *(November 30, 2007, Initial CON Submission, page 11)*

2. The Applicant proposes to provide methadone maintenance and ambulatory detoxification for the treatment of opiate addiction.[1] Methadone is taken orally on a daily basis and is used to control withdrawal symptoms, stabilize physiological processes, and improve the patient's functionality. *(November 30, 2007, Initial CON Submission, pages 11 and 12)*

3. Methadone maintenance programs are regulated by SAMHSA[2] and the WDC will apply for certification from SAMHSA to operate. *(November 30, 2007, Initial CON Submission, page 13)*

4. Ambulatory detoxification for opiate addiction is generally done by prescribing methadone as a replacement for the illicit use of opiate substances. It is used for patients who have been abusing opiates for less than a year and are appropriate candidates for daily use of methadone. Detoxification has three essential components: evaluation; stabilization; and fostering readiness to enter substance abuse treatment. *(November 30, 2007, Initial CON Submission, page 13)*

5. Dr. Njoku is a licensed physician specializing in Internal Medicine with experience in substance abuse treatment. Dr. Njoku has certification from SAMHSA to subscribe Suboxone®[3] and is a member of the American Society of Addiction Medicine. Dr. Njoku is responsible for the ongoing substance abuse treatment for drug and alcohol dependent inmates at the Osborne Correctional Facility in Somers. *(November 30, 2007, Initial CON Submission, page 8)*

6. The WDC proposes to provide its programs at 180 Poquonock Avenue, Windsor. *(November 30, 2007, Initial CON Submission, page 11)*

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[1] An Intensive Outpatient Program, also known as Day and Evening Treatment, had been proposed to be offered; the Applicant determined that the program would not be offered during the first three years of operation of the WDC to allow the WDC to focus on its core services. *(July 16, 2008, Completeness Response, page 213)*

[2] Substance Abuse & Mental Health Services Administration of the United States Department of Health and Human Services.

[3] There are five medications available for the treatment of opioid addiction: methadone, LAAM (Levo-Alpha Acetyl Methadol), buprenophine (Subutex®), buprenorphrine-naloxone (Suboxone®), and naltrexone.

7. The proposed services will be offered to individuals 18 years of age or older. The target population includes individuals who have a dependence on, or addiction to, opiates and that can be treated on an ambulatory basis. *(November 30, 2007, Initial CON Submission, page 22)*

Financial Feasibility and Cost Effectiveness of the Proposal and its Impact on the Applicant's Rates and Financial Condition
Impact of the Proposal on the Interests of Consumers of Health Care Services and the Payers for Such Services
Consideration of Other Section 19a-637, C.G.S. Principles and Guidelines

8. The Applicant reported that the total capital expenditure would consist of $10,150 for the purchase of a steel safe and alarm and camera equipment, $2,000 for construction and renovations, and $2,000 for other expenses, for a total capital expenditure of $14,150. *(November 30, 2007, Initial CON Submission, pages 38-40)*

9. The Applicant indicated that the only construction/renovation of the space will be the reinforcement of the floor below where the safe containing all controlled substances will reside. *(November 30, 2007, Initial CON Submission, page 38)*

10. The project will be financed through the Applicant's equity. *(November 30, 2007, Initial CON Submission, page 40)*

11. As of August 14, 2008, Dr. Njoku has funds available totaling $185,498. As of September 17, 2008, Dr. Njoku also has a business line of credit with an available balance of $100,000. *(September 29, 2008, Second Completeness Response, pages 310-311)*

12. The Applicant reported the following financial projections with the proposal:

Table 1: Financial Projections by Fiscal Year

Description	FY 2009	FY 2010	FY 2011
Revenue from Operations	$379,641	$1,149,106	$1,975,711
Expenses:			
Salaries and Fringe Benefits	408,000	642,720	922,983
Professional Services	8,400	9,072	9,804
Supplies and Drugs	78,448	182,235	315,277
Bad Debts	3,796	11,491	19,757
Other Operating Expenses*	137,476	203,644	273,772
Lease Expenses	30,800	30,800	30,800
Total Operating Expenses	666,920	1,079,962	1,572,393
Gain (Loss) from Operations	**($287,279)**	**$ 69,143**	**$ 403,317**

*Includes billing service, security, office supplies, insurance, and other business expenses.
Assumptions: 3% annual increase due to inflation, fringe benefits 20% of salaries.
(July 16, 2008, First Completeness Response, pages 219 and September 29, 2008, Second Completeness Response, page 305)

13. The Applicant will staff the WDC as follows: Dr. Njoku will be present from 6:30 to 10:00 a.m., 1:00 to 3 p.m. and some evenings Monday through Friday; an APRN will be in attendance from 10 to 5:30 p.m. Monday through Friday; and other staff will include a clinical coordinator, who is also a certified drug counselor and other drug counselors social workers to be present Monday through Friday and on the weekends as assigned. (*July 15, 2008, First Completeness Responses, page 222*)

14. With respect to the Applicant's operating expenses, the Intervenor testified that the Applicant dedicated insufficient funds to staffing costs. (*October 31, 2008, Prefile Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

15. The Intervenor indicated that the WDC appears understaffed due to a lack of adequate social and rehabilitative services and lack of extensive experience in opiate agonist treatment. Additionally, the intervenor indicated that the appropriate staff to dispense methadone in diskette form does not appear on the applicant's proposal. (*October 31, 2008, Prefile Testimony of Peter Strong, M.D., Medical Director of the Hartford Dispensary*)

16. The Intervenor also testified that a 1% bad debt rate is an unrealistic projection for a methadone maintenance clinic. (*October 31, 2008, Prefile Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

17. Dr. Peter Strong testified on behalf of the Intervenor that the 1% bad debt rate would only be possible if those patients who were not paying were rapidly detoxed. (*November 6, 2008, Hearing Testimony of Peter Strong, M.D., Medical Director of the Hartford Dispensary*)

18. Dr. Strong testified that he had extrapolated from the financial projections that the patients who were not paying would have to be rapidly detoxed to achieve a 1% bad debt rate; however, he also conceded that there were other ways to accomplish the 1% bad debt such as laying off employees or reducing the salaries of staff. (*November 6, 2008, Hearing Testimony of Peter Strong, M.D., Medical Director of the Hartford Dispensary*)

19. OHCA finds that the intervenors did not produce sufficient evidence demonstrating that the WDC is understaffed; however, OHCA remains concerned that in light of the testimony concerning the 1% bad debt rate and possible rapid detox of nonpaying patients to accomplish this low rate that other options such as reducing salaries or laying off staff as testified to above would not be a realistic option given the current staffing of the WDC.

20. The Applicant will lease space from the UCHE, LLC. Dr. Njoku is the sole member of UCHE, LLC. Dr. Njoku currently uses the location for his private practice on a part-time basis and he plans to consolidate all routine internal medicine care into his East Hartford office. *(November 30, 2007, Initial CON Submission, page 11)*

21. The Applicant reported the following fees for services at the Clinic:

Table 2: Projected Fee Schedule for Services

Service	Payer	Fee per Week
Methadone Maintenance	Medicaid	$92.00
	Commercial	$120.00
	Uninsured (self-pay)	$30.00
Ambulatory Detox for Opiates	Medicaid	$92.00
	Commercial	$120.00
	Uninsured (self-pay)	$30.00

(November 30, 2007, Initial CON Submission, page 206)

22. Dr. Njoku testified that he based the projected reimbursement from commercial insurers on eight years of dealing with these insurance companies in his private medical practice; however, he conceded that he is not treating with methadone maintenance in his medical practice. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

23. Dr. Njoku testified that he attempted to obtain information from Anthem and Connecticare with respect to reimbursement rates for methadone maintenance but was told that they could not divulge that information since his clinic was not yet in existence. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

24. Dr. Njoku also testified, however, that he did not believe commercial insurance reimbursement rates for methadone maintenance would significantly differ from reimbursement rates for patients treated in his internal medicine practice. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

25. Dr. Njoku testified that Connecticut's State Administered General Assistance ("SAGA") Medical Program traditionally reimburses at a lower rate than Medicaid and that it is provider specific and depends upon the location. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

26. Dr. Njoku further testified that he believed SAGA reimburses at the rate of $65 in Hartford and up to $80 in Manchester and he expects a similar rate in Windsor. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

27. Dr. Njoku testified that the financial projections for the proposal included one rate for both Medicaid and SAGA patients. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

28. The Intervenor testified that its methadone maintenance clinic in Hartford is reimbursed $63 a week per client for Medicaid. (*November 6, 2008, Hearing Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

29. The Intervenor testified that its clinic in Manchester is reimbursed $83 a week per client for Medicaid. (*November 6, 2008, Hearing Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

30. The Intervenor testified that it has located a site in Enfield to open a new clinic but it cannot purchase the site until the owner obtains approval from the Inland Wetland Commission to put a road on the property. The Intervenor further testified that it anticipates that the Medicaid reimbursement for that site would be between $80 and $83. (*November 6, 2008, Hearing Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

31. The Intervenor testified that a provider negotiates its Medicaid rates with the Department of Social Services and that it is based upon your budget for the rate and also the percentage of patients you have coming under entitlements. (*November 6, 2008, Hearing Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

32. The Intervenor testified that the SAGA rate is the same for all clients of the Hartford Dispensary and thus, is not location specific. (*November 6, 2008, Hearing Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

33. The Intervenor testified that the SAGA rate for the Hartford Dispensary is $68. (*November 6, 2008, Hearing Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

34. Based upon the Intervenor's testimony with respect to the different rates for Medicaid and SAGA and the Applicant's acknowledgment that there appeared to be different rates of reimbursement for these programs, OHCA specifically requested that the Applicant revise the financial projections and payer mix to reflect the different rates for Medicaid and SAGA patients. (*November 6, 2008, OHCA's Cross Examination of the Applicant and Instructions for Late File Number One*)

35. On December 1, 2008, the Applicant advised OHCA that it was opting not to revise the financial projections and payer mix despite the agency's request for the same because the schedule of rates for methadone maintenance from DSS showed a range of rates from $63 to $100. Additionally, the Applicant confirmed with DMHAS that the SAGA rates range from $69 to $102. Accordingly, the Applicant maintained that the rates of reimbursement are facility specific and asserted that $92.00 was a reasonable projection for both Medicaid and SAGA. (*December 1, 2008, Late File Number One*)

36. OHCA finds the Applicant failed to demonstrate that the $92 was a reasonable rate of reimbursement of both Medicaid and SAGA patients utilizing the WDC.

37. OHCA finds that the evidence demonstrates that Medicaid rates would be closer to the range of $80 to $83, as even Dr. Njoku conceded at the hearing.

38. OHCA also finds that the SAGA rate for the WDC would most likely be around $70 based on the testimony of the Intervenor. Again, Dr. Njoku conceded at the hearing that $70 would be a more reasonable projection for patients on SAGA. Moreover, the Applicant was provided with additional time to separate the Medicaid and SAGA patients and use more realistic numbers for his projected rates of reimbursement.

39. OHCA further finds that the only evidence presented by the Applicant was a range of rates obtained from DSS. It appears that the Applicant chose the higher end of the range of rates for Medicaid without regard for the location of his clinic as compared to rates received from other methadone clinics in suburban locations. Moreover, the Applicant maintained that its SAGA would be higher because of its location in Windsor despite the testimony from the intervenor that SAGA rates are not location specific but rather provider specific.

40. The Applicant provided the following projected payer mix, based on gross patient revenue, for the proposal:

Table 3: Three-Year Projected Payer Mix with the CON Proposal

Payer	FY 2008	FY 2009	FY 2010
Medicare	0	0	0
Medicaid	60.0%	60.0%	60.0%
CHAMPUS/TriCare	0	0	0
Total Government	60.0%	60.0%	60.0%
Commercial Insurers	30.0%	30.0%	30.0%
Uninsured / Self-Pay	10.0%	10.0%	10.0%
Total Non-Government	40.0%	40.0%	40.0%
Total Payer Mix	**100%**	**100%**	**100%**

(November 30, 2007, Initial CON Submission, pages 202, 203, and 204)

41. Dr. Njoku testified that he based his projections with respect to the percentage of patients that he believes would be commercially insured in the clinic's projected payer mix on the location of the WDC and the probability that the majority of these individuals would be working and have commercial insurance. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

42. Dr. Njoku also testified, however, that he had based his projections of 60% government payers on an application by New Era to provide methadone maintenance at a clinic in New Haven. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

43. Dr. Njoku testified that the WDC will accept SAGA patients and that he included SAGA patients with his projections under Medicaid. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

44. Dr. Njoku estimated that out of the 60% of patients he had included under Medicaid, about 40% would be Medicaid and the rest would be SAGA. (*November 6, 2008,*

Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.)

45. Upon further questioning by the presiding officer with respect to how many patients in the Windsor area would be on SAGA, Dr. Njoku admitted that he did not have "concrete information" but there are SAGA patients in Windsor. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

46. The Applicant further testified that patients with commercial insurance generally predominate in Windsor and that urban areas would typically have more Medicaid and SAGA patients. (*November 6, 2008, Hearing Testimony of Edwin Njoku, M.D., Chief Executive Officer of Windsor Dispensary Clinic, Inc.*)

47. The Intervenor testified that approximately 50% of its patients come under entitlements, approximately 30% are under Title XIX (Medicaid) and 20% are under SAGA. (*November 6, 2008, Hearing Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

48. The Intervenor also testified that the percentage of patients coming under entitlements rarely exceeds 52 to 53%; therefore, the Intervenor testified that the Applicant's projection of 60% government payers on its payer mix seemed high. (*November 6, 2008, Hearing Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

49. According to the Intervenor, the number of patients on methadone treatment with commercial coverage in methadone treatment programs in Connecticut is between 5-10%. (*October 31, 2008, Prefile Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

50. The Intervenor further testified that it does not have any contract with commercial insurance carriers because it does not have enough patients with commercial insurance to negotiate rates with the carriers. (*November 6, 2008, Hearing Testimony of Paul McLaughlin, Executive Director of the Hartford Dispensary*)

51. OHCA finds that the Applicant's testimony with respect to his payer mix was inconsistent and lacks credibility. Specifically, Dr. Njoku testified that the WDC would have more commercial payers because of its suburban location and also acknowledged that urban areas would typically have more Medicaid and SAGA patients. Moreover, Dr. Njoku conceded that he did not have concrete information regarding the number of patients in Windsor that would be on SAGA.

52. Dr. Njoku claimed on the one hand that the WDC would have more patients with commercial insurance because of its suburban location but on the other hand testified that he based the projection for 60% of government payers solely on New Era's application for a methadone maintenance clinic in the city of New Haven.

53. OHCA finds that the testimony of the Intervenor with respect to the payer mix for a methadone maintenance facility was credible.

54. Although the WDC might have a slightly higher number of commercially insured patients than experienced by facilities in urban locations, OHCA finds that the projection that 30% of patients utilizing the WDC would have commercial insurance is unrealistically high and the Applicant failed to provide any evidence to support this projection.

55. OHCA further finds that the Applicant's projection that 60% of the patients will have Medicaid or SAGA is inflated as well. The Applicant provided no evidence for this and even conceded that urban areas typically have more patients coming under Medicaid and SAGA.

56. OHCA finds that the payer mix is more likely to be as follows: 50% under Medicaid and SAGA, 10% with Commercial Insurance and 40% Uninsured. The Applicant's projections with respect to patients with commercial insurance and patients under Medicaid and SAGA appear to be inflated in order to demonstrate a profit in FY 2009 and 2010.

57. OHCA finds that in light of the questionable projections with respect to both the payer mix and the rates of reimbursement for the proposal that the Applicant's financial projections are not reasonable.

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. CON applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

Windsor Dispensary Clinic, Inc. ("WDC" or "Applicant") is a not-for-profit corporation established by Edwin Njoku, MD to provide substance abuse services. WDC proposes to establish and operate methadone maintenance and ambulatory detoxification programs for treatment of opiate abuse or dependency. Methadone, which is taken orally on a daily basis, is used to control withdrawal symptoms, stabilize physiological processes, and improve the functionality of individuals with opiate addictions. The Applicant proposes to locate the program at 180 Poquonock Avenue, Windsor, in a building that is currently owned by Dr. Njoku and used for his private practice on a part-time basis.

Based upon the evidence, OHCA finds that the Applicant's payer mix and projected rates of reimbursement for Medicaid and SAGA are unreasonable. The Applicant projected the number of commercially insured patients based solely upon an assumption that there would be more patients with commercial insurance in Windsor. (FINDING OF FACT 41) The Intervenor through experience dealing with its own methadone maintenance clinics within Connecticut, testified that the number of patients with commercial insurance seeking methadone treatment is closer to 5-10%. (FINDING OF FACT 49) Similarly, the Applicant projected a high number of patients with Medicaid and SAGA and relied solely upon information from a CON application by New Era to establish a methadone maintenance clinic in the city of New Haven. (FINDING OF FACT 42) Although the Applicant agreed that urban areas would have higher numbers of patients with Medicaid, it estimated that 60% of its patients would be on Medicaid and SAGA. (FINDING OF FACT 46) Moreover, the Intervenor, who operates clinics in urban and suburban locations, testified that percentage of patients coming under Medicaid and SAGA is rarely higher than 52-53%. (FINDING OF FACT 48) Accordingly, OHCA concludes the Applicant's payer mix projections are unrealistic.

With respect to the projected fee schedule, the Applicant also projected high rates of reimbursement despite evidence to the contrary. The Applicant utilized a table from DSS showing the range of Medicaid rates for methadone maintenance clinics ranging from $63.00 to $100 and chose $92 as the WDC's rate of reimbursement, asserting that it was reasonable to use a higher rate because of the location of the clinic in Windsor. (FINDING OF FACT 35) Yet the Applicant also admitted during the hearing that the WDC was likely to have a reimbursement rate closer to $80 for its Medicaid patients, particularly in light of the Intervenor's testimony that its Manchester clinic has a Medicaid rate of $83. (FINDING OF FACT 26, 37) Similarly, the Applicant was unable to provide credible evidence with respect to SAGA rates for reimbursement and Dr. Njoku claimed that the SAGA rates for the WDC would be similar to the Medicaid rates for the Manchester Hartford Dispensary location. (FINDING OF FACT 26) Following the Intervenor's

testimony that SAGA is not location specific but rather provider specific, however, the Applicant conceded that the financial projections should be adjusted to reflect appropriate rates as it appeared that the SAGA rate would be closer to $70. (FINDING OF FACT 38) Although the Applicant was provided with additional time within which to revise the financial projections by separating SAGA and Medicaid patients and utilizing more realistic numbers for the rates of reimbursement, the Applicant chose not to revise the financial projections and maintained that $92 was a reasonable rate for both Medicaid and SAGA patients at the WDC. (FINDING OF FACT 35) Although OHCA appreciates the difficulty the Applicant purportedly experienced in obtaining more concrete information with respect to rates from DSS and DMHAS, OHCA does not find sufficient evidence on the record to support the Applicant's assertion that WDC would receive reimbursement on the higher end of these ranges solely because of the location of the clinic.

Utilizing unrealistic rates of reimbursement and a payer mix with an unusually high number of commercially insured patients, the Applicant still projected a loss in the first year and modest gains in the second and third years of operation. If OHCA utilizes more realistic projections for both the payer mix and rates of reimbursement, the Applicant is more likely to experience losses in each of the first three years of operation. For example, OHCA found that the following payer mix would be more likely for the WDC: 50% Medicaid/SAGA; 10% Commercial Insurance and 40% Uninsured. (FINDING OF FACT 56.) Although OHCA determined that reimbursement for SAGA patients would be closer to $70, the Applicant was unable to provide a percentage of SAGA patients versus Medicaid patients. Accordingly, OHCA will utilize a reimbursement of $80 for both Medicaid and SAGA patients. Additionally, OHCA will utilize Applicant's rate of $120 for commercial insurers despite the fact that no evidence was presented in support of this rate. Finally, OHCA will also utilize the Applicant's rate of $30 for the uninsured. Based on these numbers, OHCA found that the following projections would be more likely:

Year 1

Applicant estimates a total of 4,030 Units (Patient Weeks)

Medicaid 50% @ $80	2015 x $80	$161,200
Commerical 10% @ $120	403 x $120	$ 48,360
Uninsured 40% @ $30	1612 X $30	$ 48,360
	Total	$257,920

Applicants has projected operating expenses of $666,920; therefore, subtracting the expenses from revenue ($265,980 - $666,920) would result in **a *loss of $409,000***

Year 2

Applicant estimates a total of 12,199 units

Medicaid 50% @ $80	6100 x $80	$488,000
Commerical 10% @ $120	1220 x $120	$ 146,400

Uninsured 40% @ $30	4879 X $30	$ 146,370
	Total	$780,770

With Operating Expenses of $1,079,962, the applicant would have a ***loss of $299,192***

Year 3

Applicant estimates a total of 20,974 units

Medicaid 50% @ $80	10,487 x $80	$838,960
Commerical 10% @ $120	2,097 x $120	$ 251,640
Uninsured 40% @ $30	8390 x $30	$ 251,700
	Total	$1,342,300

Applicant estimates operating expenses of $1,572,393, which would result in a ***loss of $230,093***

Based upon the above numbers, it is clear that the Applicant is likely to experience losses in each of the first three years of operations. Although the Applicant has presented evidence showing availability of $185,000 in his personal accounts and a $100,000 line of credit, losses in all three years would quickly use up these funds. Moreover, in light of the evidence questioning whether the Applicant has allowed enough funds for sufficient staffing of the WDC and whether the allowance for 1% bad debt is realistic, there is a possibility that the losses could be even more significant. (FINDINGS OF FACT 13-19) Accordingly, OHCA questions the Applicant's ability to provide the appropriate continuity and level of care for methadone patients in light of such significant financial losses.

In light of all of the evidence on the record demonstrating that the Applicant's projected payer mix and fee schedule are unreasonable, OHCA concludes that the Applicant has failed to demonstrate the project is financially feasible. The financial projections are largely dependent upon the Applicant seeing a high number of commercially insured clients with a projected rate of reimbursement of $120, having significantly higher rates of reimbursement for Medicaid and SAGA patients than those experienced by providers of similar services in nearby towns, and having a much lower number of uninsured patients without any evidence to support the same. Given the questionable numbers, OHCA finds that the financial projections are unreasonable and lacking in reliability and therefore, the application is denied.

Order

Based upon the foregoing Findings and Rationale, the Certificate of Need application of Windsor Dispensary Clinic, Inc. to establish and operate methadone maintenance and ambulatory detoxification programs for substance abuse in Windsor, Connecticut, at a total capital expenditure of $14,150 is hereby DENIED.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Department of Public Health
Office of Health Care Access

10-27-09
Date

Cristine A. Vogel
Deputy Commissioner